MDR: M4-02-4161-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $5,262.25 for the date of service 07/02/01.
   b. The request was received on 06/28/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement located on the Table of Disputed Services
   b. UB-92
   c. TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to Medical Dispute Resolution
   b. UB-92
   c. TWCC 62 form
   d. Methodology
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the provider on 07/15/02. The provider did not respond per Rule 133.307 (g)(3). Therefore, the commission could not forward any additional documentation to the carrier per Rule 133.307 (g)(4). The carrier's three day response dated 07/10/02 is included and will be reviewed. The response is reflected as Exhibit II.

III. PARTIES' POSITIONS

1. Requestor: Position Statement located on the Table of Disputed Services
   "Carrier denied per code 'F' which is not applicable to treatment or services for which no 'MAR' is established. Per the Commission instructions, code 'F' cannot be used to deny or reduce payment for billed services for which there is no 'MAR'. Therefore, denial is inappropriate. Carrier is not reimbursing facility consistently. In addition, Carrier did not provide payment exception codes for all billed charges."

2. Respondent: No Position Statement found in Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/02/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $6,217.25; the amount paid is $900.00; the amount in dispute is $5,262.25.

3. The carrier denied the billed services by codes:
"G,226 – INCLUDED IN GLOBAL CHARGE";
"F722 – O/P TREATMENT OF 30-60 MINUTES IN THE O.R. ARE PAID NOT TO EXCEED INPATIENT SETTING AND PER SECTION 413.011 (B) OF THE TEXAS WC ACT."
"F – Reduced According to Fee Guideline."

4. The service was performed at an ambulatory surgical center. No medical documentation was submitted by the provider to indicate to what procedure or service was performed.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…."

The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Rule 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the Commission's instructions or provide the provider with sufficient explanation to allow the provider to understand the reason for the denial. The carrier's denial codes failed to meet Rule 134.401 (a) (4). Therefore, additional reimbursement **is** recommended in the amount of **$5,262.25**.

The above Findings and Decision are hereby issued this 12th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $5,262.25 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 12th day of March 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/dmm